

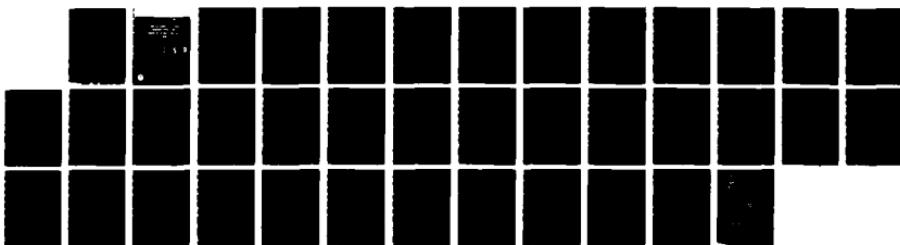
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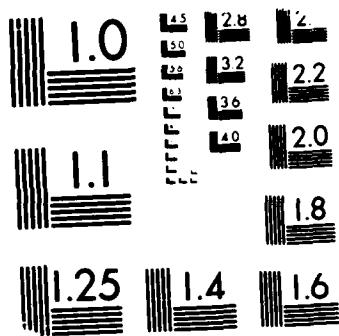
CLINICAL AND CULTURAL PERSPECTIVES ON MENTAL ILLNESS IN 1/1
THE US NAVY(U) NAVAL HEALTH RESEARCH CENTER SAN DIEGO
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CLINICAL AND CULTURAL PERSPECTIVES ON MENTAL ILLNESS IN THE U. S. NAVY

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NAVAL MEDICAL RESEARCH AND DEVELOPMENT COMMAND
BETHESDA, MARYLAND



CLINICAL AND CULTURAL PERSPECTIVES ON MENTAL ILLNESS IN THE U.S. NAVY



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To expedite communication of our research, this is a preprint of a paper submitted to Culture, Medicine and Psychiatry and should be submitted as a personal communication.

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SUMMARY

Problem

Previous research on mental disorders among Navy personnel has been extensive, and several potential risk factors have been identified. However, a meaning-centered approach is required as a complement to earlier epidemiologic investigations for a complete understanding of the cultural context of mental illness in the U.S. Navy.

Objective

The object of this paper is to examine the meaning systems of the patient, clinician, and organization and determine how they influence the process of referral, diagnosis, and treatment of Navy personnel in an outpatient setting.

Approach

Data on Navy personnel with symptoms of mental illness were collected at four outpatient clinics in the San Diego, California area between November 1982 and June 1986. These data were compiled into an automated data base at the Naval Health Research Center. Four specific stages of a mental illness event were selected for examination: precipitating factors, referral source, DSM-III diagnosis, and clinician recommendation. Frequencies of various categories within each stage were examined for a sample-wide description of mental illness events, and chi-square tests of independence were employed in comparisons of ethnic group patterns within each stage.

Results

Most of the patients were young ($X=23.9$ years), Non-Hispanic, white males. Approximately half of the patients were referred to the clinic from their respective commands; the remainder were sick call-, other medical facility-,

brig-, chaplain-, legal officer-, or self-referrals. Depression and anxiety were the most common precipitating factors for outpatient treatment, followed by dissatisfaction with the Navy, marital and interpersonal problems, and disciplinary problems. Almost half of the primary diagnoses given to the outpatients were either V Codes, Additional Codes, or personality traits with no evidence of mental illness. The most common recommendations given the outpatient sample were no further follow-up, administrative separation from the Navy, and further outpatient treatment. Important ethnic group differences were observed at each stage of the illness event.

Conclusion

A clinician evaluates each outpatient using a meaning system represented in DSM-III. However, he or she must also consider the significance of the presenting behavior for both the patient and the military organization. Within the patient's meaning system, the sociocultural background of the patient, represented in terms of ethnic identity, influences patterns of expression, referral, diagnosis, and treatment of mental illness. Symptoms may not have the same significance in the three meaning systems, and the needs of the patient and the organization may conflict with one another. The objectivity of a clinical diagnosis cannot be taken for granted.

Recommendation

Additional research should be conducted to identify each of the variations within the three major systems of meaning which comprise the mental health care system in the Navy.

Clinical and Cultural Perspectives on Mental Illness in the U.S. Navy

Introduction

Historically, mental illness has been a serious problem in the military services in times of both war and peace (Arthur 1966; Gunderson 1971). Among U.S. Navy enlisted males, the incidence of new admissions for mental disorders during the 1960s remained constant at approximately 1,000 per 100,000 men per year (Gunderson, Looney, and Goffman 1975). By the 1970s, however, the incidence of mental disorders began to increase slightly, accounting for approximately 14.5 percent of all inpatient hospital admissions among enlisted Navy personnel (Palinkas and Colcord 1983). Over a 11-year period between 1965 and 1976, the admission rate for mental disorders among this group was 1,286 per 100,000 persons per year with an average length of hospitalization of 28.5 days, accounting for approximately 2.4 million noneffective days (Gunderson and Colcord 1982). Between 1974 and 1979, the hospital admission rates for Navy enlisted white and black males was 1,544 and 1,789 per 100,000 men per year, respectively (Palinkas and Colcord 1983). Psychoses have traditionally accounted for roughly 10 percent of all psychiatric hospitalizations of enlisted males while neuroses (including psychophysiological disorders) accounted for 21 percent, personality disorders for 63 percent, and acute situational maladjustment (including combat fatigue and battle stress) for 6 percent (Gunderson, Looney, and Goffman 1975).

Previous research on mental disorders among Navy personnel has been extensive, and several potential risk factors have been identified. Officers have been found to have a much lower incidence rate than enlisted men (Gunderson, Arthur, and Richardson 1968), and enlisted men have a much lower rate than enlisted women. Age has also been found to be related to incidence

with a high rate for 17 year old males, a sharp drop in incidence for 18 to 19 year olds, a fairly constant incidence rate over a wide age range, and an increase in rate in the oldest age groups (Gunderson and Arthur 1966). Length of service and paygrade, which are highly associated with age, were also found to account for the observed patterns of uneven distribution of mental illness as well as occupational specialty. Ethnic group differences in disease incidence and inpatient hospitalization rates have also been observed. Higher than expected rates of schizophrenic and other psychotic disorders among Blacks and substance use (i.e., alcoholism) disorders among Native Americans have been observed in earlier studies (Hoiberg, Berard, and Ernst 1981; Palinkas and Colcord 1985; Palinkas 1987). Plag, Arthur and Goffman (1970) conducted a longitudinal study of 11,000 naval enlistees who entered the service in 1960. During the four-year follow-up period, 5.5 percent were admitted to the sick call list for psychiatric conditions at some time during their first term of enlistment and another 3.2 percent were administratively discharged from the service because of severe emotional pathology without admission to the sick list. A variety of characteristics, including level of schooling, Armed Forces Qualification Test Score, family stability, number of expulsions from school, reason for enlistment, etc., were significantly different for psychiatric patients and control subjects.

However, an understanding of mental illness in the U.S. Navy requires the application of a meaning-centered approach (Good and Good 1981) as a complement to the largely epidemiologic methods of the earlier research. In such an approach, "the cultural or meaningful character of symptoms and the clinical task of understanding and interpreting these symptoms are central issues" (Good and Good 1981:167). The network of meanings embedded in the etiology, symptomatology, and treatment of mental illness in the U.S. Navy

represents the convergence of three major cultural systems: clinical, organizational, and sociocultural. The clinical system is manifested in the evaluation, diagnosis, and treatment of symptoms by health care providers who respond to the needs of both the command and the patient in inpatient and outpatient settings. The organizational system includes the beliefs and expectations held throughout the Navy regarding the effects of mental illness on performance and military readiness, variations in the tolerance of deviant behavior labelled as symptomatic of mental disorder, and the discrepancy between normative and pragmatic rules pertaining to the disposition of individuals experiencing various forms of mental illness. The sociocultural system refers to the social and cultural background of the patient; the risk for various forms of mental disorder associated with certain components of this background such as age, sex, socioeconomic status, and ethnicity; and the behavioral manifestations of a disease in the form of illness.

The object of this paper is to examine these three meaning systems and to indicate how they influence the process of referral, diagnosis, and treatment of Navy personnel exhibiting various forms of mental illness. We begin with the premise that health care systems are social and culturally constructed. As described by Kleinman (1980:24):

In the same sense in which we speak of religion or language or kinship as cultural systems, we can view medicine as a cultural system, a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions. In every culture, illness, the responses to it, individuals experiencing it and treating it, and the social institutions relating to it are all systematically interconnected. The totality of these interrelationships is the health care system. Put somewhat differently, the health care system, like other cultural systems, integrates the health-related components of society. These include patterns of belief about the causes of illness; norms governing choice and evaluation of treatment; and socially-legitimated statuses, roles, power relationships, interaction settings, and institutions.

However, the sociocultural background of Navy personnel represents a multi-

plicity of cultural systems, all of which are implicated in variations in patterns of belief, norms governing choice and evaluation, statuses, relationships, and settings. Thus, one of the issues central to this examination is whether differences in cultural meanings significantly alter the experience and symptoms among members of different ethnic groups in the same organizational environment.

Methods

Our examination of the cultural foundations of mental illness in the U.S. Navy is based on data collected at four Navy outpatient clinics in the San Diego, California area between November 1982 and June 1986. Study subjects include 10,498 men and women who visited these clinics during this period for whom data collected at the initial visit were available. All but 1 percent of the study subjects were active-duty Navy personnel; the remainder were dependents or retired military personnel.

Data collection procedures have been described in detail elsewhere (Baker, Glogower, and Congleton 1983; Chaffee, Baker, and Kolb 1983). Data collection was accomplished using two forms, the Administrative/Encounter Form and the Follow-up Encounter Form. Individuals were scheduled for an initial visit by clinic personnel upon receipt of a Consultation Sheet (Standard Form 513) at the Navy Fleet Mental Health Support Unit (FMHSU) located at each outpatient clinic or other appropriate referrals received by the clinic. Patients were also seen on an emergency basis as necessary.

The Administrative/Encounter Form contains three sections completed in order by the patient, the technician (corpsperson or civilian), and the clinician. Section 1, completed by the patient, contains demographic data, including name, social security number (SSN), date of initial interview, sex,

age, patient status (active duty, dependent, etc.), paygrade, length of service in months and years, recruit status, ethnicity (a choice of seven categories), branch of service, and marital status. Section 2, completed by the technician, contains information on date consult received, referral source, principal service provided, need for screening for special programs, whether or not the visit was an emergency, and a special code indicating the clinician and facility. Section 3, completed by the clinician, contains a list of 26 precipitating factors used by the clinician in describing the reason(s) for the patient's initial visit. The review of the patient's service record, health record, and consult form is noted by the clinician. Primary diagnosis is determined by the clinician using the Diagnostic and Statistical Manual of Mental Disorders (DSM-III or DSM-IIIR) (American Psychiatric Association 1980). Personality traits were recorded for personnel having conditions resembling personality disorders but which did not meet DSM-III criteria. Patient disposition, recommendation(s), and results from special program screenings if applicable, also were recorded.

Patients returning for a follow-up visit for further evaluation or treatment use the Follow-up Encounter Form. This form is completed by the technician and clinician. Section 1, completed by the technician contains patient name, social security number, visit date, principal service provided, screening for special programs, whether or not the visit was an emergency, and clinician and facility code. Section 2 contains the primary diagnosis which may or may not be the same as that recorded on the Administrative/Encounter Form or any previous Follow-up forms. Clinician's recommendation and applicable screening program results are also noted.

Four specific stages of a mental illness event were selected for examination: precipitating factors, referral source, DSM-III diagnosis, and

clinician recommendation. Information on the first two stages was obtained from the Initial Encounter Form. Information on primary diagnosis and clinician recommendation was obtained from the Follow-up Encounter Form if available; otherwise it was obtained from the Initial Encounter Form.

Due to the lack of data on the Navy population at risk in the San Diego area during the study period, rates of disease incidence or prevalence could not be calculated. However, the focus of this study was on cultural patterns of illness as reflected in referral, symptomatology, diagnosis, and recommendation, and not disease etiology. Hence, our examination was restricted to the outpatient sample and not the population from which it was drawn. In addition, only five of the seven ethnic groups were used in our analysis of sociocultural differences with respect to each stage of a mental illness event; Asian Americans and the group of outpatients who labelled themselves as belonging to "other" ethnic groups were excluded because of the small sample size. Two-tailed chi-square tests of independence were used to test for differences between each minority ethnic group and the numerically dominant Non-Hispanic white group with respect to the percentage distributions in each category of referral, symptomatology, diagnosis, and recommendation.

Results

A descriptive summary of the outpatient sample and the treatment process is provided in Table 1. Most of the patients (65.5%) were 24 years or younger with a mean age of 23.9 for the entire sample. Males outnumbered females by a ratio of 10 to 1. Non-Hispanic whites comprised the largest ethnic group among outpatients, followed by blacks, Hispanics, and Filipinos. Sex and ethnic distributions among the outpatient sample appear to correspond

Table 1. Characteristics of Mental Health Outpatients, 1982-1986

<u>Age</u>	<u>Number</u>	<u>Percent*</u>
18-19	2,642	24.5
20-24	4,108	41.0
25-29	1,868	18.6
30-34	937	9.3
35-39	451	4.5
40 or older	204	2.0
Missing Data	468	
<u>Sex</u>		
Male	9,076	90.4
Female	966	9.6
Missing Data	456	
<u>Ethnic Group</u>		
Non-Hispanic White	8,080	80.4
Black	1,219	12.1
Hispanic	405	4.0
Filipino	141	1.4
Asian American	46	0.5
Native American	82	0.8
Other	81	0.8
Missing Data	444	
<u>Precipitating Factor</u>		
Depression	2,843	28.2
Anxiety	2,766	27.5
Problem with Navy Life	2,381	23.6
Wants Out of Navy	1,992	19.8
Job Stress	1,620	16.1
Other Stress	1,597	15.9
Interpersonal Problems	1,565	15.5
Disciplinary Probems	1,295	12.9
Alcohol Abuse	1,203	11.9
Marital Difficulty	1,066	10.6
Job Problems	1,004	10.0
Suicide Ideation	884	8.8
Inappropriate Behavior	869	8.6
Sleep Disturbance	832	8.3
Physical Complaints	825	8.2
Family Separation	668	6.6
Drug Abuse	609	6.0
Suicide Gesture	269	2.7
Behavior Problems	203	2.0
Enuresis	155	1.5
Homicidal Ideation	88	0.9
None Apply	919	9.1
Missing Data	425	

Table 1 (continued)

<u>Referral Source</u>	<u>Number</u>	<u>Percent*</u>
Command	4,960	49.4
Sick Call	2,498	24.9
Other Medical Service	1,229	12.2
Self-Referral	433	4.3
Chaplain	275	2.7
Brig	239	2.4
Legal	88	0.9
Other	325	3.2
Missing Data	451	
 <u>DSM-III Category</u>		
Additional Codes	3,493	35.1
Adjustment Disorder	1,913	19.2
Personality Disorders	1,205	12.1
V Codes	1,044	10.5
Substance Use Disorders	1,008	10.1
Youth Disorders	411	4.1
Anxiety Disorders	166	1.7
Psychological Factors Affecting Physical Condition	161	1.6
Paranoid Disorders/Psychotic Disorders		
Not Elsewhere Classified	141	1.4
Personality Traits	126	1.3
Affective Disorders	85	0.9
Psychosexual Disorders	82	0.8
Somatoform and Dissociative Disorders	38	0.4
Disorders of Impulse Control	36	0.4
Schizophrenic Disorders	30	0.3
Organic Mental Disorders	16	0.2
Missing Data	543	
 <u>Recommendations</u>		
No Follow-up Indicated	3,239	30.9
Administrative Separation	2,672	25.5
Return for Further Outpatient Treatment	1,950	18.6
Return for Further Evaluation	415	4.0
Family Service Center	410	3.9
Counseling and Assistance Center (CAAC)	403	3.8
Alcohol Rehabilitation Program	337	3.2
Admission to Hospital	313	3.0
Medical Board	165	1.6
Drug Rehabilitation Program	108	1.0
CHAMPUS	37	0.4
Other	1,571	15.0
Missing Data	22	

* Because more than one precipitating factor or recommendation may be listed for each outpatient, percentages in these two categories exceed 100%.

to Navy-wide population distributions for this period (Doering and Hutzler 1982). The outpatient sample appears to have a larger proportion of younger individuals than is found in the Navy as a whole; however, this may be attributed to the overrepresentation of young recruits from the Naval Training Center in San Diego in our sample (Kolb, Chaffee, and Coben 1982).

Depression and anxiety were the most common precipitating factors for outpatient treatment, followed by dissatisfaction with the Navy (problems with Navy, wants out of Navy, job problems, and job stress). Marital difficulties and interpersonal problems, disciplinary problems, and substance abuse constituted other important clusters of factors precipitating the initial outpatient visit.

Approximately half of the outpatients were referred to the mental health unit of each clinic from the individual's command. The referral may come from the command's medical department (usually an independent duty corps-person if the individual was assigned to a ship), but frequently the source was the individual's immediate supervisor. Sick call visits comprised approximately one quarter of the outpatient referrals in our sample. Individuals may report for clinic sick call either on the advice of their ship's medical department (if assigned to a ship), their immediate supervisor (if either on a ship or a shore duty station), or he or she may report to sick call on his or her own initiative. The reason for the sick call visit may either be directly related or incidental to the psychiatric problems. In the latter instance, an individual may report for another medical condition (e.g., an accidental injury, somatic complaints) and be referred to the mental health unit subsequent to the initial evaluation by the physician on duty at sick call. Other sources of referral include other medical units (i.e., emergency medicine, inpatient psychiatric wards), individuals who make

their own appointments without first reporting for sick call, the command chaplain or legal officer, or the regional brig.

Almost half (46.9%) of the primary diagnoses given by the attending clinician to the sample outpatients fell within three categories: V Codes for conditions not attributable to a mental disorder that are a focus of attention or treatment; Additional Codes, including an unspecified mental disorder (nonpsychotic), no diagnosis or condition on Axis I or Axis II, and diagnosis deferred on Axis I or Axis II; and personality traits such as paranoid trait, schizoid trait, antisocial trait, and compulsive trait. These categories refer to disruptions in behavior which typically interfere with the individual's work performance and military readiness, but cannot be attributed to a specified psychiatric disorder requiring treatment. Adjustment disorders, personality disorders, and substance use disorders comprised the major specific psychiatric disorders in the outpatient sample.

Upon evaluation by the attending clinician, the most common recommendations given to the outpatient sample were no further follow-up, administrative separation from the Navy, and further outpatient treatment.

Table 2 provides a comparison of the distribution of DSM-III diagnostic categories by referral source. A disproportionate number of somatoform and dissociative disorders and psychophysiological disorders were sick call referrals. Approximately one half of the referrals from other medical facilities were diagnosed using additional codes. A disproportionate number of substance use disorders, psychosexual disorders, personality disorders, and V Codes were referred to the mental health unit by the brig. A disproportionate number of organic mental disorders, substance use disorders, schizophrenic disorders, psychosexual disorders, and personality disorders were referred to the mental health unit by the individual's command legal officer.

Table 2. Percentage Distribution of DSM-III Diagnostic Category by Referral Source

	Sick Call	Other Medical	Command	Brig	Legal Officer	Chaplain	Self-Referral	Other
Additional Codes	26.6	49.8	39.2	23.4	36.5	27.3	23.6	25.8
Adjustment Disorders	21.6	13.3	19.9	3.9	9.4	35.2	16.3	16.3
Personality Disorders	11.0	11.7	11.3	23.4	21.2	18.0	10.3	14.4
V Codes	14.3	7.1	7.2	17.7	4.7	7.1	29.9	13.1
Substance Abuse Disorders	10.5	7.8	9.5	26.8	18.8	4.9	6.5	19.0
Youth Disorders	3.6	1.9	5.9	0.4	1.2	2.2	1.3	1.3
Anxiety Disorders	2.1	2.1	1.1	0.0	0.0	1.5	2.8	2.3
Psychophysiological Disorders	2.9	1.0	1.4	0.0	0.0	0.4	1.3	0.7
Paranoid/Psychotic Disorders	1.4	1.7	1.5	0.9	1.2	1.5	1.0	1.0
Personality Traits	1.9	1.0	0.8	0.4	1.2	0.4	2.0	3.6
Affective Disorders	1.5	0.9	0.4	0.9	0.0	0.4	1.3	1.3
Psychosexual Disorders	0.9	0.3	0.8	1.7	2.4	0.4	2.8	0.0
Somatoform/Dissociative Disorders	0.8	0.7	0.2	0.0	0.0	0.0	0.3	0.0
Impulse Control Disorders	0.5	0.3	0.3	0.4	0.0	0.0	0.8	0.7
Schizophrenic Disorders	0.3	0.3	0.3	0.0	2.4	0.4	0.0	0.3
Organic Mental Disorders	0.1	0.2	0.2	0.0	1.2	0.4	0.0	0.3

$$\chi^2 = 974.569, \text{ d.f.}, 105, p. < 0.0001.$$

More than one third of the referrals made by a chaplain were for adjustment disorders. Approximately one half of the self-referrals were given unspecified or nonpsychiatric diagnoses. A disproportionate number of anxiety disorders, psychosexual disorders, and impulse control disorders were self-referrals. A disproportionate number of substance use disorders and non-

psychiatric personality traits were referred to the unit from other sources.

A comparison of the referral sources of the five major ethnic groups of outpatients is provided in Table 3. Hispanic outpatients were referred to the four mental health units from other medical services and their respective commands somewhat less often than were Non-Hispanic whites ($\chi^2=7.68$, $p.=0.006$ and $\chi^2=5.92$, $p.=0.015$, respectively). Black outpatients also were referred to a mental health unit from other medical services significantly less often than Non-Hispanic whites ($\chi^2=20.98$, $p. < 0.001$). However, the percentage of black outpatients who were referred from their respective commands and from the regional brig was significantly greater than the percentages of Non-Hispanic white outpatients from the same referral sources ($\chi^2=19.81$, $p. <$

Table 3. Percentage Distribution of Referral Sources by Ethnic Group

	Non-Hispanic White (N=8,052)		Hispanic (N=404)		Ethnic Group		Filipino		Native American (N=82)	
	N	%	N	%	Black (N=1,214)	%	N	%	N	%
Command	3895	48.4	221	45.7*	671	55.3***	67	48.2	34	41.5
Sick Call	2007	24.9	93	23.0	289	23.8	35	25.2	23	28.0
Other Medical Service	1048	13.0	33	8.2**	101	8.3***	20	14.4	12	14.6
Self	360	4.5	14	3.5	39	3.2*	9	6.5	3	3.7
Chaplain	226	2.8	16	4.0	27	2.2	0	0.0	3	3.7
Brig	180	2.2	8	2.0	43	3.5**	3	2.2	2	2.4
Legal Officer	71	0.9	5	1.2	6	0.5	2	1.4	4	4.9***
Other	265	3.3	14	3.5	38	3.1	3	2.2	1	1.2

* p. < 0.05 ** p. < 0.01 *** p. < 0.001

0.001 and $\chi^2=7.12$, p.=0.008, respectively). Native American outpatients were referred to the clinics by their command legal officer somewhat more often than Non-Hispanic white outpatients ($\chi^2=10.15$, p. < 0.001).

As indicated by Table 4, no significant differences were observed between Hispanic outpatients and non-Hispanic whites with the exception of more frequent reports of interpersonal problems among Hispanics ($\chi^2=4.41$, p.=0.03). Black outpatients reported symptoms of depression ($\chi^2=5.09$, p.=0.02), anxiety ($\chi^2=12.84$, p. < 0.001), alcohol abuse ($\chi^2=3.94$, p.=0.047), wanting out of the Navy ($\chi^2=14.60$, p. < 0.001), family separation ($\chi^2=4.21$, p.=0.04), sleep disturbance ($\chi^2=6.40$, p.=0.01), and no precipitating factors ($\chi^2=3.87$, p.=0.49) significantly less often, but reported symptoms of disciplinary problems ($\chi^2=10.54$, p.=0.001), job problems ($\chi^2=7.61$, p.=0.006), and other precipitating factors ($\chi^2=9.59$, p.=0.002) significantly more often than the Non-Hispanic white outpatients. Filipino outpatients reported significantly more symptoms of inappropriate behavior ($\chi^2=8.36$, p.=0.004), physical complaints ($\chi^2=9.53$, p.=0.002), homicidal ideation ($\chi^2=16.13$, p. < 0.001), and sleep disturbance ($\chi^2=3.73$, p.=0.053) than Non-Hispanic whites, but significantly fewer symptoms of alcohol abuse ($\chi^2=7.54$, p. < 0.01), wanting out of the Navy ($\chi^2=6.74$, p. < 0.01), and problems with Navy life ($\chi^2=5.84$, p.=0.01). A significantly greater percentage of Native Americans reported disciplinary problems, but a significantly smaller percentage indicated that they wanted out of the Navy than Non-Hispanic white outpatients ($\chi^2=4.43$, p.=0.04 and $\chi^2=5.22$, p.=0.02, respectively).

With respect to the percentage distribution of DSM-III diagnoses contained in Table 5, no significant differences were observed between Hispanics and Non-Hispanic whites or between Native Americans and Non-Hispanic whites. In the latter instance, however, the lack of statistical significance may be

Table 4. Percentage Distribution of Precipitating Factors by Ethnic Group

	Non-Hispanic White (N=8,071)	Hispanic (N=405)	Ethnic Group		Filipino (N=141)	Native American (N=82)		
			Black					
			N	%				
Depression	2286	28.3	130	32.1	306	25.2*		
Anxiety	2264	28.1	113	27.9	281	23.1***		
Problem With Navy Life	1937	24.0	109	26.9	266	21.9		
Wants Out of Navy	1663	20.6	87	21.5	193	15.9***		
Job Stress	1311	16.2	59	14.6	190	15.6		
Other Stress	1247	15.5	64	15.8	231	19.0**		
Interpersonal Problems	1259	15.6	47	11.6*	197	16.2		
Disciplinary Problems	1006	12.5	46	11.4	193	15.9**		
Alcohol Abuse	986	12.2	54	13.3	124	10.2*		
Marital Difficulty	857	10.6	37	9.1	125	10.3		
Job Problems	785	9.7	32	7.9	150	12.3**		
Suicide Ideation	710	8.8	41	10.1	92	7.6		
Inappropriate Behavior	677	8.4	42	10.4	105	8.6		
Sleep Disturbance	687	8.5	35	8.6	77	6.3**		
Physical Complaints	650	8.1	32	7.9	100	8.2		
Family Separation	548	6.8	37	9.1	63	5.2*		
Drug Abuse	489	6.1	22	5.4	85	7.0		
Suicide Gesture	216	2.7	6	1.5	38	3.1		
Unspecified Behavior Problem	162	2.0	9	2.2	19	1.6		
Enuresis	125	1.5	6	1.5	18	1.5		
Homicidal Ideation	63	0.8	4	1.0	13	1.1		
None	769	9.5	29	7.2	94	7.7*		
					10	7.1		
					5	6.1		

* p. < 0.05 ** p. < 0.01 *** p. < 0.001

a. Numbers in parentheses refer to the number of outpatients and not the number of precipitating factors. Each outpatient may report more than one factor.

Table 5. Percentage Distribution of DSM-III Diagnostic Categories by Ethnic Group

	Non-Hispanic White (N=7,677)		Hispanic (N=392)		Ethnic Group Black (N=1,166)		Filipino (N=127)		Native American (N=78)	
	N	%	N	%	N	%	N	%	N	%
Additional Codes	2650	34.5	136	34.7	480	41.2***	47	37.0	33	42.3
Adjustment Disorders	1499	19.5	82	20.9	211	18.1	21	16.5	9	11.5
Personality Disorders	931	12.1	47	12.0	125	10.7	10	7.9	11	14.1
V Codes	789	10.3	38	9.7	119	10.2	22	17.3*	7	9.0
Substance Use Disorders	789	10.3	38	9.7	112	9.6	4	3.1*	10	12.8
Youth Disorders	352	4.6	23	5.9	21	1.8***	3	2.4	0	0.0
Anxiety Disorders	114	1.5	4	1.0	23	2.0	5	3.9	2	2.6
Psychophysiological Disorders	128	1.7	6	1.5	13	1.1	5	3.9	0	0.0
Paranoid/Psychotic Disorders NEC	97	1.3	5	1.3	32	2.7***	3	2.4	1	1.3
Personality Traits	104	1.4	5	1.3	7	0.6*	0	0.0	0	0.0
Affective Disorders	71	0.9	1	0.3	3	0.3	1	0.8	3	3.8
Psychosexual Disorders	67	0.9	2	0.5	8	0.7	1	0.8	0	0.0
Somatoform/Dissociative Disorders	28	0.4	1	0.3	2	0.2	2	1.6	0	0.0
Impulse Control Disorders	27	0.4	0	0.0	6	0.5	1	0.8	1	1.3
Schizophrenic Disorders	19	0.2	3	0.8	3	0.3	2	1.6*	0	0.0
Organic Mental Disorders	12	0.2	1	0.3	1	0.1	0	0.0	1	1.3

* p. < 0.05 ** p. < 0.01 ***p. < 0.001

attributed to the small number of Native American outpatients. Native American outpatients were diagnosed as having adjustment disorders less often than Non-Hispanic white outpatients; the difference was significant at the 0.10 level, however. Black outpatients were diagnosed as having paranoid or psychotic disorders not elsewhere classified or having conditions listed

under the category of Additional Codes somewhat more often than Non-Hispanic whites ($\chi^2=14.43$, p. < 0.001 and $\chi^2=19.27$, p. < 0.001, respectively), but were given primary diagnoses of youth disorders and personality traits significantly less often than Non-Hispanic white outpatients ($\chi^2=18.74$, p. < 0.001 and $\chi^2=4.06$, p.=0.04, respectively). Filipino outpatients exhibited a significantly larger percentage of schizophrenic disorders and V Code diagnoses ($\chi^2=4.00$, p.=0.045 and $\chi^2=5.92$, p.=0.01, respectively), and a significantly smaller percentage of substance use disorders than Non-Hispanic whites ($\chi^2=6.19$, p.=0.01). Compared with Non-Hispanic whites, Filipino outpatients also reported higher percentages of diagnoses of anxiety disorders, psychophysiological disorders, and somatoform and dissociative disorders; however, the differences were statistically significant at the 0.10 level.

Table 6 indicates the distribution of the different ethnic groups by clinical recommendation. Compared to Non-Hispanic white outpatients, recommendations for administrative separation from the Navy were significantly more frequent among Hispanic outpatients ($\chi^2=6.30$, p.=0.01) and significantly less frequent among Filipino outpatients ($\chi^2=12.14$, p. < 0.001). Black outpatients were given recommendations for hospital admission somewhat more often than Non-Hispanic white outpatients ($\chi^2=5.46$, p.=0.02); conversely, they were also recommended for further outpatient treatment significantly less often than the Non-Hispanic white outpatients ($\chi^2=10.63$, p.=0.001). Filipino outpatients were recommended for administrative separation from the Navy significantly less often than Non-Hispanic white outpatients ($\chi^2=12.14$, p. < 0.001). The percentage of Filipino outpatients who were given recommendations of no further follow-up was also greater than the percentage of Non-Hispanic whites given the same recommendation; the difference between the two ethnic groups was only marginally significant, however ($\chi^2=3.17$, p.=0.07).

Table 6. Percentage Distribution of Recommendations by Ethnic Group

	Non-Hispanic White (N=8,061) ^a		Hispanic (N=405)		Ethnic Group Black (N=1,216)		Filipino (N=141)		Native American (N=82)	
	N	%	N	%	N	%	N	%	N	%
No Follow-up Indicated	2494	30.9	128	31.6	389	32.0	54	38.3	29	35.4
Administrative Separation	2103	26.1	129	31.9*	322	26.5	18	12.8***	17	20.7
Further Outpatient Treatment	1479	18.3	70	17.3	176	14.5**	30	21.3	17	20.7
Return for Further Evaluation	313	3.9	9	2.2	58	4.8	5	3.5	3	3.7
Family Service Center	303	3.8	15	3.7	51	4.2	7	5.0	3	3.7
Counseling and Assistance Center	298	3.7	21	5.2	56	4.6	4	2.8	2	2.4
Alcohol Rehabilitation	265	3.3	17	4.2	33	2.7	1	0.7	1	1.2
Admission to Hospital	223	2.8	14	3.5	49	4.0*	6	4.3	4	4.9
Medical Board	129	1.6	4	1.0	22	1.8	2	1.4	0	0.0
Drug Rehabilitation	87	1.1	4	1.0	10	0.8	0	0.0	1	1.2
CHAMPUS	26	0.3	2	0.5	3	0.2	0	0.0	1	1.2
Other	1192	14.8	60	14.8	199	16.4	23	16.3	15	18.3

* p. < 0.05 ** p. < 0.01 *** p. < 0.001

a. The numbers in parentheses refer to the number of outpatients and not the number of recommendations. Each outpatient may receive more than one recommendation.

Discussion

Obviously the data presented here do not provide a complete picture of mental illness in the Navy. An important component of mental illness, psychiatric hospitalizations, was excluded from our analysis. Many of the relationships observed between ethnicity and referral, precipitating factors, diagnoses, and recommendations were confounded by ethnic group differences in age and sex distributions. In addition, due to the lack of data on the popu-

lation at risk, the role of ethnicity in the etiology of mental disorders was not examined. Nevertheless, the objective of this paper was to provide a description of the cultural framework within which a clinician in an outpatient setting treats his patient. By examining outpatient clinic patients only, we selected a frame of the Navy mental health system for the purpose of identifying those components of the medical, personnel, and organizational cultures responsible for its character and content. Hence, the problem of confounding variables of disease risk and the etiology of mental disorders was of less concern to us than the association of systems of meaning with discrete behaviors or events.

The problems attended to by clinicians at Navy mental health units are a reflection of the clinical significance of various symptoms indicating the presence or absence of mental disorder, the demographic and sociocultural composition of the population at risk, and the needs of the naval organization and the extent to which various forms of mental illness may compromise those needs. The clinical significance of various symptoms is based on the meaning system comprising the modern medical care system, found throughout the United States, of which Navy health care providers are a part. Elements of behavior are interpreted in light of the DSM-III nomenclature, which is implicitly influenced by the values and beliefs of the particular society in which it evolved (Hughes 1985:8). Similarly, prescribed treatment for Navy psychiatric outpatients adheres to certain rules and standards adopted throughout the mental health profession.

These standards and principles, however, are influenced by the specific character of both the patients and the organization served by these professionals. The traditionally large percentage of personality disorders among both inpatients and outpatients in the Navy may be attributed to the high

proportion of Navy personnel under the age of 25 and, perhaps also, the characteristics or risk factors among the segment of the general population from which the enlistees are drawn. The large percentage of adjustment disorders has also been a traditional characteristic of Navy mental health. These disorders are often transient and represent an inability to cope with the demands of Navy life. Navy recruits undergoing a crisis of identity during the recruit training phase of their enlistment are particularly vulnerable to this form of mental illness (Bourne 1967). The physical and psychosocial stressors associated with leaving home--often for the first time--rigorous physical training, and subjection to relatively rigid forms of discipline and conduct, may produce a "maladaptive reaction indicated by either impairment in social or occupational functioning or symptoms that are in excess of a normal and expected reaction to the stressor" (American Psychiatric Association 1980:299).

The large percentage of substance use disorders, specifically alcohol abuse, is also a response to the psychosocial stressors associated with Navy life, including disruption of family ties, limited financial resources, frequent relocations, exposure to occupational hazards and stressors, and adherence to military regulations. This particular response to stress, however, has traditionally been a fundamental part of the organizational culture of the Navy, a culturally-constituted mechanism for coping with stress. Consumption of alcohol has been associated with the sailor's life for centuries.

The image of the drunken sailor has appeared frequently in story and song. Every Navy man has recollections of his own or his shipmates' benders or binges on shore leave and liberty. Inexpensive liquor, available at package stores and at clubs for men and women of every rank, has been a prominent element in navy life ashore. "Happy hours" and frequent celebrations of promotions, special achievements, missions accomplished, and arrivals and departures are all synonymous with alcohol consumption. While drinking has been socially expected, if not encouraged, the

individual serviceman who could not control his drinking and thereby was unable to conform to navy rules and regulations was subject to disciplinary action. Fines, demotions, and ultimately premature discharge from the service often resulted (Kolb and Gunderson 1977:184).

Because of the serious potential consequences, both the alcohol abusers and supervisory personnel were likely to deny difficulties and cover up excessive drinking (Kolb and Gunderson 1985). This was particularly true for officers and senior enlisted personnel because of their value to the command in terms of knowledge and experience and a sense of dedication to and concern for fellow members of the "Navy family." Referral and potential loss of a senior enlisted chief suffering from an alcohol problem may harm the efficiency of a command more than toleration of the drinking. Alcohol abuse, therefore, was regarded as a behavioral problem more from a clinical standpoint than from an organizational standpoint unless the problem began to seriously impair work performance.

On the other hand, the large percentage of V Codes and Additional Codes reflect behavioral problems from an organizational standpoint but not necessarily from a clinical standpoint. V Codes are given in cases where no mental disorder has been found or where the scope of the diagnostic evaluation has not been adequate to determine the presence or absence of a mental disorder (American Psychiatric Association 1980:331). They refer to conditions such as malingering, adult antisocial behavior, bereavement, or marital problems which are not indicative of a mental disorder as defined by DSM-III but which affect work performance. Similarly, additional codes are given when insufficient information exists to warrant a specific psychiatric diagnosis. A mental disorder may be suspected because of impaired work performance but not necessarily supported by the clinical meaning system represented by DSM-III.

In addition to the importance of symptomatology from the standpoint of impaired performance, the influence of the organizational meaning system in the medical culture of mental illness in the Navy is also evidenced in the large percentage of referrals from the command. In a nonmilitary setting, an individual may experience particular behavior disorders for years without seeking treatment in a modern health care system, either because care is available from other health care sectors (Kleinman, Eisenberg, and Good 1977), or because the symptoms do not seriously impair social ties or work performance. Two factors associated with military culture preclude this from happening in the Navy, however. First, within the Navy's organizational structure everyone, from the lowly seaman apprentice to the Secretary of the Navy, is subject to performance evaluations by a superior. Anything compromising that performance is potentially subject to action on the part of the superior because any degradation in the performance of a subordinate reflects the performance of the superior as well. Second, impaired performance is also subject to referral and evaluation because of its potential effect on the health, safety, and readiness of the entire command. Personnel in key positions on ships, for instance, could jeopardize the safety of the entire crew if vigilence or accuracy were affected by a drinking problem or psychotic episode. The behavior of one is perceived in the organizational meaning system to affect the behavior of many; thus caution is exercised to identify and eliminate deviant behavior, either through clinical treatment or administrative sanctions such as demotion or discharge (Chaffee and Bally 1982). As Kolb and his colleagues (1982:8) observe, command referrals usually reflect a process of "'weeding out' those individuals who are not going to adjust to the Navy."

The system of meanings associated with the organizational culture of the

Navy also influences the process of treatment seeking. As Sussman and her colleagues (1987) observe, numerous factors may affect decisions regarding treatment-seeking, including characteristics of the individuals themselves, characteristics of the symptoms, and attitudes and beliefs about the causes and proper treatment of psychiatric problems (Sussman, Robins and Earls 1987: 187). As noted earlier, while cases of mental disorder may go unnoticed in the general population, it is extremely difficult to exhibit symptoms of mental illness in the Navy which are not apparent to supervisors and peers. The source of a referral for outpatient treatment, however, appears to depend on the nature of the disorder and its associated symptoms. Referrals which are given V Codes and Additional Codes as the primary diagnosis are likely to come from the command if they affect work performance (Chaffee and Bally 1982); Kolb, Chaffee, and Coben 1982). They may come from the brig or command legal officer if they contribute to violations of military or civilian law and are defined by the organizational culture as criminal behavior. Relative to other referrals, a large percentage of somatoform and psychophysiological disorders come from sick call referrals, due to the somatic or physical symptoms which are recognized either by the patient, his supervisor, or his command's medical officer. Self-referrals reflect self-perceived problems which may or may not be symptomatic of a psychiatric disorder. These referrals are precipitated by some form of psychological distress or discomfort, but the symptoms are frequently perceived by the clinician to be more "normal" or less severe than other forms of mental illness.

The organizational meaning system also influences the pattern of recommendations given by clinicians to mental health outpatients. As indicated by the list in Tables 1 and 6, there are three sets of options exercised by a clinician when prescribing a course of action for the outpatient. He or she

may suggest no further follow-up, particularly if a V Code or Additional Code is given as the primary diagnosis. He or she may refer the outpatient for further evaluation or treatment in a more specialized setting such as a hospital psychiatric ward, alcohol or drug rehabilitation program, or Counseling and Assistance Center. Finally, he or she may recommend that the outpatient be discharged from the Navy. One out of every four outpatients in our sample received this last recommendation. These individuals possess certain clinical and demographic characteristics which suggest that treatment would be inappropriate. A study by Gunderson and Arthur (1967) indicated that years of service and diagnoses of psychoneuroses or acute situational maladjustment (adjustment disorders) were positively correlated with restoration to duty after an inpatient psychiatric hospitalization; length of hospitalization and diagnoses of psychoses or character and behavior (i.e., personality) disorder were negatively correlated with restoration. Chaffee and Bally (1982) also noted that senior enlisted personnel and officers were most likely to be scheduled for follow-up visits, reflecting a bias among clinicians to expend more effort and attention on career-oriented and senior personnel. Rather than retain and provide treatment to younger, junior enlisted personnel with personality disorders, the clinical system adheres to the values of the organizational system, particularly in light of the fact that among first-term enlistees, the probability that a psychiatric patient will render effective military service is only one in ten (Plag, Arthur, and Goffman 1970). Concern for the needs of the organization takes precedence over the needs of the individual when no satisfactory compromise between the two sets of needs is possible. It should be pointed out, however, that in many if not most instances, administrative separation is in the interest of both the command and the individual, particularly when a precipitating factor is the inability

to adjust or cope with the demands of Navy life.

At the same time the clinician must consider the meaning system of the organization when treating a mental health outpatient, he or she must also consider the meaning system of the patient. This cultural system is evident in terms of both values and meanings shared by all Navy personnel and values and meanings adhered to by different subgroups of the Navy population. The values and meanings shared by all Navy personnel are reflected in the list of precipitating factors contained in Table 1. This list actually contains two distinct categories: symptoms such as depression, anxiety, and disciplinary problems; and stressors such as Navy life in general, specific duty assignments, and interpersonal relations. As evidenced from the percentages listed in this table, some symptoms and stressors are more common than others. These numbers are evidence of general patterns of stress associated with Navy life and constitute a range of culturally appropriate and inappropriate reasons for distress and forms of its expression.

However, within the Navy, expressions of distress and their precipitating stressors are influenced by a number of factors including the socio-cultural background of active duty personnel. For example, the lower percentage of interpersonal problems among Hispanics, compared with Non-Hispanic whites, may reflect the strength of social ties among the former group. The prophylactic benefit of these ties, particularly close family ties, among Hispanics in the U.S. has been suggested in other studies (Jaco 1960; Rubel 1966). Smaller percentages of depression, anxiety, alcohol abuse, wanting out of the Navy, family separation, and sleep disturbance among blacks reflect a lowered risk for these factors, relative to Non-Hispanic whites. However, the difference in percentage distributions are more likely due to differences in the expression of distress associated with Navy life. As

Kennedy (1973:1165) observes, "it seems evident that in most cases, the ethnic label generally indicates a set of cultural role behaviors that allows the individual under psychic stress certain prerogatives, and prescribes a sequence of culturally defined responses from the group." Whereas Non-Hispanic white patients expressed this distress through depression, anxiety, alcohol abuse, etc., black patients expressed this distress in the form of disciplinary problems, job problems, and other, unspecified symptoms and complaints. Adebimpe (1981) has reported a similar pattern of symptom expression among black and white patients in the general population. Similarly, cultural differences in the expression and causes of psychological distress are evident in the comparisons between Native Americans, Filipinos and Non-Hispanic whites. Native American outpatients reported a greater percentage of disciplinary problems but expressed dissatisfaction with Navy life less often than Non-Hispanic white outpatients. Filipino outpatients exhibited a greater percentage of symptoms of inappropriate behavior, physical complaints, sleep disturbance, and homicidal ideation, but a smaller percentage of drinking problems than Non-Hispanic white outpatients. Filipino outpatients also expressed dissatisfaction with the Navy (i.e., wants out of the Navy, problem with Navy life) less often than their Non-Hispanic white counterparts. This discrepancy reflects their commitment to remaining in the Navy, often as long as 20 to 30 years. For members of this ethnic group, "a U.S. Navy career, in no matter how humble a capacity, represents a greater opportunity and reward than that offered them in their native rural barrios or villages, from which the naval enlistees are largely drawn" (Duff and Arthur 1967:836). Consequently, the attrition rate among Filipinos in recruit training is very much lower than among United States citizens. Less than one percent of Filipinos are lost during recruit training as opposed to

an approximately eight percent attrition for all other recruits (Duff and Arthur 1967:837). However, this commitment may occasionally be at great personal cost as Filipinos experience acculturative stress in addition to the organizational stressors experienced by other Navy personnel (Duff and Arthur 1967; Palinkas 1987).

Ethnic groups also exhibit significant differences in their patterns of referral to the mental health units. Sussman and her colleagues (1987) found a similar pattern of self-referral between blacks and whites with depressive symptoms and suggested two alternative explanations for this pattern:

Whites may tend to perceive and interpret minor episodes of depression in ways more congruent with psychiatry--or the medical paradigm--than blacks. They may recognize the presence of a problem, interpret the problem as a medical one, and seek care sooner than blacks. It is possible that blacks may more frequently feel they have a reason to be depressed and consider their symptoms to be normal outcomes of everyday problems, stress, and strain.... Alternatively, blacks may believe their depressive symptoms to be symptomatic of some other physical illness and interpret them as medical, but not mental health or emotional, problems (Sussman, Robins and Earls 1987:195).

The high percentage of referrals from the brig among black outpatients and the command legal officer among Native American outpatients, relative to Non-Hispanic white outpatients, corresponds to the high percentage of disciplinary problems among these two groups. Thus, among blacks and Native Americans, a culturally distinct pattern of precipitating factors and referral is evident. The greater percentage of command referrals among black outpatients, relative to their Non-Hispanic white counterparts, also corresponds to a significantly greater percentage of reports of job problems and unspecified diagnoses, which may indicate that blacks are more likely to be viewed as behavioral problems, although lacking specific psychiatric diagnoses, than Non-Hispanic white personnel.

Despite the wide differences in precipitating factors and referral

sources, there were remarkably few ethnic group differences with respect to DSM-III diagnoses. Blacks did exhibit a significantly greater percentage of paranoid and nonspecific psychotic disorders and Additional Codes than Non-Hispanic whites, and Filipino outpatients were more often diagnosed as having a schizophrenic disorder than their Non-Hispanic white counterparts. These patterns have been observed in other studies. Statistics of various diagnostic categories from individual clinical settings show that higher rates of schizophrenia and other psychoses are usually accompanied by low rates of affective disorders in blacks (Steinberg et al 1977; Adebimpe 1981). Duff and Arthur (1967) found that psychosis, most commonly paranoid schizophrenia, was the predominant syndrome among Filipino sailors hospitalized for a mental disorder, with personality disorder diagnoses lagging far behind in number. These differences may be due to differences in the ethnic group distribution of risk factors associated with each disorder, cultural patterns of expression of "illness," or patterns in the evaluation of symptoms expressed by members of one ethnic group by clinicians belonging to another group. Adebimpe (1981) attributes the differential diagnoses among white and black psychiatric patients to cultural differences between patient and clinician, cultural differences in expression of psychological distress (i.e., symptomatology) among black and white patients, and culturally-biased diagnostic instruments. In a similar vein, Duff and Arthur (1967:837) note that "it has long been axiomatic in naval psychiatry that Filipino mental patients presented a stereotyped clinical syndrome in which hypochondriasis and paranoia were prominent. It was equally axiomatic that meaningful two-way communication between physician and patient did not appear to exist."

Finally, ethnic group differences were observed with respect to clinician recommendations. The percentage of outpatients requiring hospital

admissions is greater among all four minority ethnic groups than it is for Non-Hispanic whites. This would appear to support the thesis that non-white ethnic groups experience greater psychological distress than whites because they delay treatment or lack access to the modern health care system (Sussman, Robins and Earls 1987; Lin, Inui, Kleinman, and Womack 1982). Only for black outpatients, however, is this difference statistically significant. Black outpatients are also less likely to be recommended for further outpatient treatment than Non-Hispanic white outpatients, which may be due, as Adebimpe suggests, either to the perceived severity of the diagnosis or the cultural differences between patient and clinician and its impact on the treatment process.

Conclusion

Our examination of a sample of outpatients seen at four Navy mental health units indicated that the medical culture of mental health in the Navy is characterized by the interaction of three distinct systems of meaning: the clinician's meaning system, the organization's meaning system, and the patient's meaning system. At each of four stages in an illness event--precipitating factors, referral, diagnosis, and recommendation--each of these meaning systems exerts a specific influence on the behavior of patient, clinician, and organization.

From this analysis, it is evident that the objectivity of a clinical diagnosis of mental disorder cannot be taken for granted. As Stein (1985:2) suggests, "it is important to pay attention to the culture of the physician (together with other health care decision makers) as much as it is everyone's obligation to be keenly interested in and observant of the influence of the patient's culture in medical care." Second, in a pluralistic society or

organization, the factors precipitating an episode of mental illness are influenced by the nature of the organizational system and the sociocultural background of its members. Cultural, along with personal, meanings influence what kinds of social and environmental stimuli are perceived as stressful, and those perceptions in turn provoke certain forms of conflict, behavior, and psychopathology that occur among members of a particular society or organization (Kiev 1972; Kleinman 1980). Cultural beliefs and experience also help determine which symptoms are most threatening and bothersome (Kleinman 1980:139).

In his analysis of culture-bound disorders, Hughes asserts that:

if one accepts the demonstrated depth and pervasiveness of culture in shaping behavior, both in internal ideational models and external motoric manifestations, then it follows that at a phenomenological level there can be culturally distinctive ways of being mentally disordered regardless of the extent of specific organic involvement. In this respect, biology provides the base and culture provides the vehicle, the form for translation of biologic factors into conceptualization at the behavioral level in the same way that anatomic and neurologic factors provide the substrate and mechanism for speech, which in its observable form is a distinctive, culturally-programmed language (Hughes 1985:5-6).

In the U.S. Navy, the culturally-programmed language which translates biological factors of psychiatric disorder into conceptualization at the behavioral level of a mental illness event reflects a polyglot of meanings, symbols, values, and behaviors which are fundamental to the cultural systems of the clinician, the military organization, and the patient.

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